

<i>SERFF Tracking Number:</i>	<i>NYLC-126159557</i>	<i>State:</i>	<i>Arkansas</i>
<i>Filing Company:</i>	<i>New York Life Insurance and Annuity Corporation</i>	<i>State Tracking Number:</i>	<i>42453</i>
<i>Company Tracking Number:</i>	<i>209-538, ET AL.</i>		
<i>TOI:</i>	<i>L08 Life - Other</i>	<i>Sub-TOI:</i>	<i>L08.000 Life - Other</i>
<i>Product Name:</i>	<i>Life &amp; Annuity Single Premium Application</i>		
<i>Project Name/Number:</i>	<i>Life &amp; Annuity Single Premium Application/209-538, et al.</i>		

## Filing at a Glance

Company: New York Life Insurance and Annuity Corporation

Product Name: Life & Annuity Single Premium    SERFF Tr Num: NYLC-126159557    State: Arkansas  
Application

TOI: L08 Life - Other	SERFF Status: Closed-Accepted For Informational Purposes	State Tr Num: 42453
-----------------------	-------------------------------------------------------------	---------------------

Sub-TOI: L08.000 Life - Other	Co Tr Num: 209-538, ET AL.	State Status: Approved-Closed
Filing Type: Form		Reviewer(s): Linda Bird

Authors: Team Leader, Sean Hebron    Disposition Date: 11/04/2009

Hebron

Date Submitted: 05/22/2009	Disposition Status: Accepted For Informational Purposes
----------------------------	------------------------------------------------------------

Implementation Date Requested: On Approval

State Filing Description:

## General Information

Project Name: Life & Annuity Single Premium Application

Project Number: 209-538, et al.

Requested Filing Mode: Review & Approval

Explanation for Combination/Other:

Submission Type: New Submission

Overall Rate Impact:

Filing Status Changed: 11/04/2009

Deemer Date:

Submitted By: Sean Hebron

Filing Description:

Re: New York Life Insurance and Annuity Corporation (NYLIAC)

Flexible Single Premium Variable Universal Life Insurance and/or Deferred Variable Annuities Application Form 209-538;

Temporary Coverage Agreement Form 21620.200;

Flexible Single Premium Universal Life Insurance and/or Single Premium Deferred Fixed Annuities Form 309-548;

Temporary Coverage Agreement Form 21620.300.

Status of Filing in Domicile:

Date Approved in Domicile:

Domicile Status Comments:

Market Type: Individual

Group Market Size:

Group Market Type:

Explanation for Other Group Market Type:

State Status Changed: 05/22/2009

Created By: Sean Hebron

Corresponding Filing Tracking Number:

SERFF Tracking Number: NYLC-126159557 State: Arkansas  
Filing Company: New York Life Insurance and Annuity Corporation State Tracking Number: 42453  
Company Tracking Number: 209-538, ET AL.  
TOI: L08 Life - Other Sub-TOI: L08.000 Life - Other  
Product Name: Life & Annuity Single Premium Application  
Project Name/Number: Life & Annuity Single Premium Application/209-538, et al.  
NAIC #: 82691596  
FEIN #: 13-3044743

Dear Commissioner:

We are enclosing for your approval new application forms for use when applying for our Single Premium Universal and Variable Universal Life and Annuity products. We expect to introduce these new forms in August 2009, or as soon thereafter as administratively possible.

The following forms are enclosed:

Flexible Single Premium Variable Universal Life Insurance and/or Deferred Variable Annuities Application, Form 209-538. This application will be used to apply for our flexible single premium variable universal life insurance and deferred annuity products. The Product Selection and Premium section of this application includes the currently available single premium products that may be applied for using this application. The combination of these single premium products in one application makes it easier for the agent to address an applicant's variable insurance and annuity needs.

Temporary Coverage Agreement, Form 21620.200. If cash is taken with application form 209-538, form 21620.200 will provide a limited amount of temporary life insurance coverage on the proposed insured(s) from the date coverage begins to the date coverage terminates.

Flexible Single Premium Universal Life Insurance and/or Single Premium Deferred Fixed Annuities Form, 309-548. This application will be used to apply for our flexible single premium universal life insurance and deferred annuity products. The Product Selection and Premium section of this application includes the currently available single premium products that may be applied for using this application. The combination of these single premium products in one application makes it easier for the agent to address an applicant's universal life insurance and fixed annuity needs.

Temporary Coverage Agreement, Form 21620.300. If cash is taken with the application form 309-548, form 21620.300 will provide a limited amount of temporary life insurance coverage on the proposed insured(s) from the date coverage begins to the date coverage terminates.

We have enclosed in this filing a certification that replacement questions are included in a separate form that was previously approved by the state insurance departments.

We also have enclosed a certification that suitability questions and disclosures for variable life products will be included in separate forms.

A readability certification also is enclosed.

*SERFF Tracking Number:* NYLC-126159557      *State:* Arkansas  
*Filing Company:* New York Life Insurance and Annuity      *State Tracking Number:* 42453  
Corporation  
*Company Tracking Number:* 209-538, ET AL.  
*TOI:* L08 Life - Other      *Sub-TOI:* L08.000 Life - Other  
*Product Name:* Life & Annuity Single Premium Application  
*Project Name/Number:* Life & Annuity Single Premium Application/209-538, et al.

The policies to which this application will be used are listed in the Appendix A.

These applications and temporary conditional agreement will be used in paper. The .pdf's submitted are the typeset version that will be printed by an outside vendor and stocked for use. They will also be made available on the company intranet for printing by the agents on their personal computers.

We would appreciate receiving your approval of the enclosed forms, at your earliest convenience. If there are any questions regarding this filing, you may call me toll free at 1-877-464-0198 or email me at Linda\_E.\_LoPinto@newyorklife.com.

Sincerely,

Linda E. LoPinto  
Corporate Vice President  
Individual Life Department

Encl.

Appendix A

For use with Flexible Single Premium Variable Universal Life Insurance and/or Deferred Variable Annuities Application Form 209-538 and Temporary Coverage Agreement Form 21620.200.  
Flexible Single Premium Variable Universal Life Products

Flexible Single Premium Variable Universal Life Insurance Policy  
Form No.: 308-95      Approved: 2/25/2009

Living Benefits Rider  
Form No.: 929-495      Approved: 9/3/1991  
Deferred Variable Annuity Products

New York Life Extra Credit Variable Annuity  
Form No.208-192      Approved: 10/15/2008

New York Life Smart Value Variable Annuity  
Form No.208-191      Approved: 10/15/2008

SERFF Tracking Number: NYLC-126159557 State: Arkansas  
Filing Company: New York Life Insurance and Annuity Corporation State Tracking Number: 42453  
Company Tracking Number: 209-538, ET AL.  
TOI: L08 Life - Other Sub-TOI: L08.000 Life - Other  
Product Name: Life & Annuity Single Premium Application  
Project Name/Number: Life & Annuity Single Premium Application/209-538, et al.

**Annual Death Benefit Reset Rider**

Form No.203-305 (11/2008) Approved: 10/22/2008

**Investment Protection Plan Rider**

Form No.999-302 (11/2008) Approved: 10/22/2008

**Enhanced Beneficiary Benefit Rider**

Form No.203-304 (11/2008) Approved: 10/22/2008

For use with Flexible Single Premium Universal Life Insurance and Single Premium Deferred Fixed Annuities Application Form 309-548 and Temporary Coverage Agreement Form 21620.300.

**Single Premium Universal Life Policy**

Form No.306-130.49 Approved: 7/9/2007

**New York Life Deferred Fixed Annuity Forms:**

**New York Life Enhanced Fixed Annuity**

Form No. 207-198 Approved: 7/10/2007

**New York Life Preferred Fixed Annuity**

Regular Issue Form No.205-190

Instant Issue Form No. 205-191 Approved: 3/16/2005

**New York Life Optimal Fixed Annuity**

Form No.207-199 Approved: 7/10/2007

**New York Life Select 5 Fixed Annuity**

Form No.208-193 Approved: 3/18/2008

## **Company and Contact**

**Filing Contact Information**

Sean Hebron, Senior Contract Assistant	Sean_Hebron@nyl.com
51 Madison Avenue	212-576-2681 [Phone]
Room 606	212-447-4141 [FAX]
New York, NY 10010	

SERFF Tracking Number: NYLC-126159557 State: Arkansas  
 Filing Company: New York Life Insurance and Annuity Corporation State Tracking Number: 42453  
 Company Tracking Number: 209-538, ET AL.  
 TOI: L08 Life - Other Sub-TOI: L08.000 Life - Other  
 Product Name: Life & Annuity Single Premium Application  
 Project Name/Number: Life & Annuity Single Premium Application/209-538, et al.

### Filing Company Information

New York Life Insurance and Annuity Corporation	CoCode: 91596	State of Domicile: Delaware
51 Madison Ave	Group Code: 826	Company Type: Life
New York, NY 10010	Group Name: NYLIC	State ID Number:
(212) 576-4809 ext. [Phone]	FEIN Number: 13-3044743	

-----

### Filing Fees

Fee Required? Yes  
 Fee Amount: \$200.00  
 Retaliatory? Yes  
 Fee Explanation: \$50 per form X 4 forms = \$200.00  
 Per Company: No

COMPANY	AMOUNT	DATE PROCESSED	TRANSACTION #
New York Life Insurance and Annuity Corporation	\$200.00	05/22/2009	28059248

SERFF Tracking Number: NYLC-126159557 State: Arkansas

Filing Company: New York Life Insurance and Annuity Corporation State Tracking Number: 42453

Company Tracking Number: 209-538, ET AL

TOI: L08 Life - Other Sub-TOI: L08.000 Life - Other

Product Name: Life & Annuity Single Premium Application

Project Name/Number: Life & Annuity Single Premium Application/209-538, et al.

## Correspondence Summary

### Dispositions

Status	Created By	Created On	Date Submitted
Accepted For Linda Bird Informational Purposes		11/04/2009	11/04/2009
Approved- Closed	Linda Bird	05/22/2009	05/22/2009

### Amendments

Schedule	Schedule Item Name	Created By	Created On	Date Submitted
Form	Application for Single Premium Universal Life Insurance and/or Single Premium Deferred Fixed Annuity	Sean Hebron	11/03/2009	11/03/2009

### Filing Notes

Subject	Note Type	Created By	Created On	Date Submitted
Form Typo	Note To Filer	Linda Bird	11/02/2009	11/02/2009
Form Typo	Note To Reviewer	Sean Hebron	11/02/2009	11/02/2009

<i>SERFF Tracking Number:</i>	<i>NYLC-126159557</i>	<i>State:</i>	<i>Arkansas</i>
<i>Filing Company:</i>	<i>New York Life Insurance and Annuity Corporation</i>	<i>State Tracking Number:</i>	<i>42453</i>
<i>Company Tracking Number:</i>	<i>209-538, ET AL.</i>		
<i>TOI:</i>	<i>L08 Life - Other</i>	<i>Sub-TOI:</i>	<i>L08.000 Life - Other</i>
<i>Product Name:</i>	<i>Life &amp; Annuity Single Premium Application</i>		
<i>Project Name/Number:</i>	<i>Life &amp; Annuity Single Premium Application/209-538, et al.</i>		

## Disposition

Disposition Date: 11/04/2009

Implementation Date:

Status: Accepted For Informational Purposes

Comment: Company has corrected form 309-548AR

Rate data does NOT apply to filing.

SERFF Tracking Number: NYLC-126159557 State: Arkansas

Filing Company: New York Life Insurance and Annuity Corporation State Tracking Number: 42453

Company Tracking Number: 209-538, ET AL.

TOI: L08 Life - Other Sub-TOI: L08.000 Life - Other

Product Name: Life & Annuity Single Premium Application

Project Name/Number: Life & Annuity Single Premium Application/209-538, et al.

Schedule	Schedule Item	Schedule Item Status	Public Access
Supporting Document	Flesch Certification		Yes
Supporting Document	Application		No
Supporting Document	Replacement Certification		Yes
Supporting Document	Suitability Certification		Yes
Form	Application for Single Premium Variable Universal Life Insurance and/or Deferred Variable Annuity		Yes
Form (revised)	Application for Single Premium Universal Life Insurance and/or Single Premium Deferred Fixed Annuity		Yes
Form	Application for Single Premium Universal Life Insurance and/or Single Premium Deferred Fixed Annuity	Replaced	Yes
Form	Temporary Coverage Agreement		Yes
Form	Temporary Coverage Agreement		Yes

<i>SERFF Tracking Number:</i>	<i>NYLC-126159557</i>	<i>State:</i>	<i>Arkansas</i>
<i>Filing Company:</i>	<i>New York Life Insurance and Annuity Corporation</i>	<i>State Tracking Number:</i>	<i>42453</i>
<i>Company Tracking Number:</i>	<i>209-538, ET AL.</i>		
<i>TOI:</i>	<i>L08 Life - Other</i>	<i>Sub-TOI:</i>	<i>L08.000 Life - Other</i>
<i>Product Name:</i>	<i>Life &amp; Annuity Single Premium Application</i>		
<i>Project Name/Number:</i>	<i>Life &amp; Annuity Single Premium Application/209-538, et al.</i>		

## Disposition

Disposition Date: 05/22/2009

Implementation Date:

Status: Approved-Closed

Comment:

Rate data does NOT apply to filing.

SERFF Tracking Number: NYLC-126159557 State: Arkansas

Filing Company: New York Life Insurance and Annuity Corporation State Tracking Number: 42453

Company Tracking Number: 209-538, ET AL.

TOI: L08 Life - Other Sub-TOI: L08.000 Life - Other

Product Name: Life & Annuity Single Premium Application

Project Name/Number: Life & Annuity Single Premium Application/209-538, et al.

Schedule	Schedule Item	Schedule Item Status	Public Access
Supporting Document	Flesch Certification		Yes
Supporting Document	Application		No
Supporting Document	Replacement Certification		Yes
Supporting Document	Suitability Certification		Yes
Form	Application for Single Premium Variable Universal Life Insurance and/or Deferred Variable Annuity		Yes
Form (revised)	Application for Single Premium Universal Life Insurance and/or Single Premium Deferred Fixed Annuity		Yes
Form	Application for Single Premium Universal Life Insurance and/or Single Premium Deferred Fixed Annuity	Replaced	Yes
Form	Temporary Coverage Agreement		Yes
Form	Temporary Coverage Agreement		Yes

SERFF Tracking Number: NYLC-126159557 State: Arkansas

Filing Company: New York Life Insurance and Annuity Corporation State Tracking Number: 42453

Company Tracking Number: 209-538, ET AL.

TOI: L08 Life - Other Sub-TOI: L08.000 Life - Other

Product Name: Life & Annuity Single Premium Application

Project Name/Number: Life & Annuity Single Premium Application/209-538, et al.

## Amendment Letter

Submitted Date: 11/03/2009

### Comments:

The revised form has been attached to the submission. Thanks and have a great day!

Best Regards,  
Sean Hebron  
(212)576-2681

### Changed Items:

#### Form Schedule Item Changes:

#### Form Schedule Item Changes:

Form Number	Form Type	Form Name	Action	Form Action Other	Previous Filing #	Replaced Form #	Readability Score	Attachments
309-548AR	Application/Enrollment Form	Application for Single Premium Universal Life Insurance and/or Single Premium Deferred Fixed Annuity	Initial				50.000	309-548AR 11-09.pdf

*SERFF Tracking Number:* NYLC-126159557 *State:* Arkansas  
*Filing Company:* New York Life Insurance and Annuity *State Tracking Number:* 42453  
Corporation  
*Company Tracking Number:* 209-538, ET AL.  
*TOI:* L08 Life - Other *Sub-TOI:* L08.000 Life - Other  
*Product Name:* Life & Annuity Single Premium Application  
*Project Name/Number:* Life & Annuity Single Premium Application/209-538, et al.

**Note To Filer**

**Created By:**

Linda Bird on 11/02/2009 03:26 PM

**Last Edited By:**

Linda Bird

**Submitted On:**

11/02/2009 03:26 PM

**Subject:**

Form Typo

**Comments:**

Filing has been reopened in order for correction to be submitted.

*SERFF Tracking Number:* NYLC-126159557 *State:* Arkansas  
*Filing Company:* New York Life Insurance and Annuity *State Tracking Number:* 42453  
Corporation  
*Company Tracking Number:* 209-538, ET AL.  
*TOI:* L08 Life - Other *Sub-TOI:* L08.000 Life - Other  
*Product Name:* Life & Annuity Single Premium Application  
*Project Name/Number:* Life & Annuity Single Premium Application/209-538, et al.

**Note To Reviewer**

**Created By:**

Sean Hebron on 11/02/2009 10:05 AM

**Last Edited By:**

Sean Hebron

**Submitted On:**

11/02/2009 10:05 AM

**Subject:**

Form Typo

**Comments:**

Good Morning,

In form 309-548AR, we have noticed a typo under the Medical And Personal Information section of the application form. Question A, should read (12) months not (12) years. We would appreciate it if this filing could be re-opened so that the new form can be attached with the correct information. Thanks and have a great day!

Best Regards,

Sean Hebron

(212)576-2681

SERFF Tracking Number: NYLC-126159557 State: Arkansas

Filing Company: New York Life Insurance and Annuity Corporation State Tracking Number: 42453

Company Tracking Number: 209-538, ET AL.

TOI: L08 Life - Other Sub-TOI: L08.000 Life - Other

Product Name: Life & Annuity Single Premium Application

Project Name/Number: Life & Annuity Single Premium Application/209-538, et al.

## Form Schedule

### Lead Form Number: 209-538

Schedule Item Status	Form Number	Form Type	Form Name	Action	Action Specific Data	Readability	Attachment
	209-538AR	Application/ Enrollment Form	Application for Single Initial Premium Variable Universal Life Insurance and/or Deferred Variable Annuity			50.000	209-538AR.pdf
	309-548AR	Application/ Enrollment Form	Application for Single Initial Premium Universal Life Insurance and/or Single Premium Deferred Fixed Annuity			50.000	309-548AR 11-09.pdf
	21620.200	Application/ Enrollment Form	Temporary Coverage Initial Agreement			51.000	21620.200.pdf
	21620.300	Application/ Enrollment Form	Temporary Coverage Initial Agreement			51.000	21620.300.pdf



**NEW YORK LIFE** Application for Single Premium Variable Universal Life Insurance and/or Deferred Variable Annuity  
New York Life Insurance and Annuity Corporation (NYLIAC) (A Delaware Corporation)

Executive Office: 51 Madison Avenue, New York, NY 10010 • Home Office: 200 Continental Drive, Suite 306, Newark, DE 19713

**1. PROPOSED INSURED/ANNUITANT INFORMATION**

First Name	Middle Name	Last Name	Suffix	<input type="checkbox"/> Male <input type="checkbox"/> Female	Date of Birth (mm/dd/yyyy)
Residence: Street	City	State	Country	Zip	Home Telephone (Evening) Business Telephone (Day)
<input type="checkbox"/> Social Security No. or <input type="checkbox"/> Tax I.D. No. <input type="checkbox"/> Exempt <input type="checkbox"/> Applied for					
Country of Citizenship	Country of Birth	State of Birth	How Long Living in the USA? <input type="checkbox"/> Since Birth or _____ Years _____ Months		
Immigration Visa or Work Authorization: (If other than a US citizen)	Expiration	Occupation			
Type	Number	Month	Year		
Employer Name:	Street	City	State	Country	Zip

*If the Owner, Joint Owner, Applicant, or Payer is not the Proposed Insured/Annuitant, please provide the appropriate additional information in Section 5.*

**2. MEDICAL AND PERSONAL INFORMATION (Applies only to Single Premium Variable Universal Life Insurance)**

- A. Has the Proposed Insured used tobacco, nicotine, or any nicotine substitution product in any form in the last twelve (12) months? ..... ☐ Yes ☐ No
- B. In the last 90 days, has the Proposed Insured been recommended by a physician or other medical practitioner to undergo diagnostic procedures or tests for any symptoms, illnesses or other conditions? (If "Yes," please provide additional information in Section 7) ..... ☐ Yes ☐ No
- C. In the last two (2) years, has the Proposed Insured been admitted to a hospital or other medical facility for a medical illness or major surgical procedure? ..... ☐ Yes ☐ No
- D. In the last five (5) years, has the Proposed Insured been diagnosed by a member of the medical profession or tested positive for Human Immunodeficiency Virus (AIDS virus) or Acquired Immune Deficiency Syndrome (AIDS)? ..... ☐ Yes ☐ No
- E. In the last five (5) years, has the Proposed Insured been diagnosed, treated, tested positive for or been given medical advice by a member of the medical profession for any of the conditions below? (If "Yes," circle all applicable conditions)

1) Heart attack, chest pains, or heart disorder, angina, heart surgery, or angioplasty	<input type="checkbox"/> Yes <input type="checkbox"/> No	7) Pancreatitis, hepatitis, cirrhosis, kidney failure, or a condition requiring dialysis	<input type="checkbox"/> Yes <input type="checkbox"/> No
2) Stroke or transient ischemic attack (TIA)	<input type="checkbox"/> Yes <input type="checkbox"/> No	8) Anemia requiring blood transfusions	<input type="checkbox"/> Yes <input type="checkbox"/> No
3) Vascular disease (peripheral vascular disease, aneurysm, artery blockage)	<input type="checkbox"/> Yes <input type="checkbox"/> No	9) Any major psychiatric or mental condition requiring hospitalization	<input type="checkbox"/> Yes <input type="checkbox"/> No
4) Diabetes requiring insulin treatment	<input type="checkbox"/> Yes <input type="checkbox"/> No	10) Drug or alcohol abuse	<input type="checkbox"/> Yes <input type="checkbox"/> No
5) Any form of malignant cancer or tumor, leukemia, Hodgkin's disease, or lymphoma requiring chemo/radiation therapy	<input type="checkbox"/> Yes <input type="checkbox"/> No	11) Unexplained weight loss exceeding twenty (20) pounds	<input type="checkbox"/> Yes <input type="checkbox"/> No
6) Chronic bronchitis, emphysema (COPD), or any condition requiring oxygen therapy	<input type="checkbox"/> Yes <input type="checkbox"/> No	12) Muscular dystrophy, ALS, lupus, multiple sclerosis, seizures, Alzheimer's disease or other neurological disorder	<input type="checkbox"/> Yes <input type="checkbox"/> No

**3. PRODUCT SELECTION AND PREMIUM – If "No" is answered in Section 2 for Questions C and D, and all conditions listed in Question E, one or both products may be selected. If "Yes" is answered in Section 2 for Questions C or D, or any condition listed in Question E, only a Deferred Variable Annuity may be selected. If applicable, make check payable to NYLIAC.**

The appropriate Investor Profile(s) must be submitted with this application.

- ☐ **Single Premium Variable Universal Life Insurance** (If 'Yes' is answered to Question B in Section 2 above, do not collect life insurance premium. Temporary Coverage is not available.)  
Death Benefit Guarantee: \$ \_\_\_\_\_ Premium: \$ \_\_\_\_\_ Premium Paid: \$ \_\_\_\_\_ (Optional. If paid, must be equal to full premium.)  
☐ **Living Benefits Rider (LBR)**

- ☐ **Deferred Variable Annuity** (Annuity commencement at age 90 for all products.)

Choose one of the following annuities: ☐ [New York Life Premier Plus Variable Annuity] ☐ [New York Life Premier Variable Annuity]

Choose one of the following M&E charge options: ☐ Adjusted Premium ☐ Accumulation Value

**Optional Riders:** These riders provide benefits for a charge that may vary. Refer to the terms described in the prospectus and in the rider(s) that will be attached to your Policy, if selected here. All riders may not be available for all products and/or jurisdictions.

☐ [Annual Death Benefit Reset (ADBR)] ☐ [Investment Protection Plan (IPP)] ☐ [Enhanced Beneficiary Benefit (EBB)]

Premium: \$ \_\_\_\_\_ (Estimate the total amount, including cash with application and anticipated exchange amounts)

Premium Paid: \$ \_\_\_\_\_ (Indicate amount of cash with application)



#### 4. BENEFICIARY(IES)

- If more than one Beneficiary is named, indicate the class and percentage for each. Each class for each product must total 100%.
- If applicable, use Section 7, "Additional Details," to provide additional Beneficiary information.

<b>Single Premium Variable Universal Life Insurance Beneficiaries</b> <i>(if applicable)</i>		<b>Deferred Variable Annuity Beneficiaries</b> <i>(if applicable)</i>	
<input type="checkbox"/> <b>Trust</b> <i>(Provide details in Section 7)</i>		<input type="checkbox"/> <b>Same Beneficiary designations for both products</b>	
<input type="checkbox"/> <b>UTMA/UGMA</b> <i>(Provide details in Section 7)</i>		<input type="checkbox"/> <b>Surviving Spouse Under Joint Spousal Ownership</b>	
		<input type="checkbox"/> <b>Trust</b> <i>(Provide details in Section 7)</i>	
		<input type="checkbox"/> <b>UTMA/UGMA</b> <i>(Provide details in Section 7)</i>	
<u><b>Class</b></u>		<u><b>Class</b></u>	
<b>Primary</b>	_____ Name (First, Middle, Last, Suffix)	<b>Primary</b>	_____ Name (First, Middle, Last, Suffix)
	_____ Relationship to Proposed Insured		_____ Relationship to Proposed Annuitant
<input type="checkbox"/> <b>Primary</b>		<input type="checkbox"/> <b>Primary</b>	
<input type="checkbox"/> <b>Contingent</b>	_____ Name (First, Middle, Last, Suffix)	<input type="checkbox"/> <b>Contingent</b>	_____ Name (First, Middle, Last, Suffix)
	_____ Relationship to Proposed Insured		_____ Relationship to Proposed Annuitant

#### 5. OTHER PARTY INFORMATION

<b>A. Owner Information</b> <i>(if not the Proposed Insured/Annuitant)</i>			
<input type="checkbox"/> Individual <input type="checkbox"/> Trust <input type="checkbox"/> Corp. If Individual, provide:			
Owner (First, Middle, Last, Suffix)	Birth Date (mm/dd/yyyy)	<input type="checkbox"/> Male <input type="checkbox"/> Female	<input type="checkbox"/> SSN or <input type="checkbox"/> Tax I.D. No. <input type="checkbox"/> Exempt <input type="checkbox"/> Applied for
Residence (Street, City, State, Country, Zip Code)		Home Telephone (Evening)	Business Telephone (Day)
Country of Citizenship	Country of Birth	State of Birth	Relationship to Proposed Insured/Annuitant
If not a US citizen, type of immigration visa or work authorization: _____ Number: _____ Expiration (mm/yyyy): _____			
If Trust:      Name of Trust		Date of Trust	State Where Trust Established
Name of Trustee(s)		Relationship of Trustee(s) to Proposed Insured/Annuitant	
Trust Beneficiary(ies)		Relationship of Trust Beneficiary(ies) to Proposed Insured/Annuitant	
Is the trust a grantor trust? <input type="checkbox"/> Yes <input type="checkbox"/> No   If "Yes" and the grantor is an individual: _____			
Grantor's Name (First, Middle, Last, Suffix)			
If joint ownership: The joint owner <input type="checkbox"/> <b>is</b> <input type="checkbox"/> <b>is not</b> the Proposed Insured/Annuitant. <i>(If not the Proposed Insured/Annuitant, provide information for joint owner in Section 7, "Additional Details." Unless otherwise specified in Section 7, ownership will be joint with right of survivorship.)</i>			
<b>B. Applicant Information</b> <i>(if not the Proposed Insured/Annuitant or Owner)</i>			
Name (First, Middle, Last, Suffix)	Birth Date (mm/dd/yyyy)	<input type="checkbox"/> Male <input type="checkbox"/> Female	<input type="checkbox"/> SSN or <input type="checkbox"/> Tax I.D. No. <input type="checkbox"/> Exempt <input type="checkbox"/> Applied for
Residence (Street, City, State, Country, Zip Code)		Relationship to Proposed Insured/Annuitant	
<b>C. Payer Information</b> <i>(if not the Proposed Insured/Annuitant)</i>			
Same as <input type="checkbox"/> Owner <input type="checkbox"/> Applicant			
Name (First, Middle, Last, Suffix)	Birth Date (mm/dd/yyyy)	<input type="checkbox"/> Male <input type="checkbox"/> Female	<input type="checkbox"/> SSN or <input type="checkbox"/> Tax I.D. No. <input type="checkbox"/> Exempt <input type="checkbox"/> Applied for
Residence (Street, City, State, Country, Zip Code)		Relationship to Proposed Insured/Annuitant	
Relationship to Owner <i>(if other than Proposed Insured/Annuitant)</i>			
<b>D. Secondary Addressee</b> - Owner may designate a secondary addressee to receive notice of potential lapse of coverage.			
Name (First, Middle, Last, Suffix)		Residence (Street, City, State Country, Zip Code)	



## 6. SALES INTERVIEW

In which language and dialect(s) was the sales interview conducted? Language: \_\_\_\_\_ Dialect(s): \_\_\_\_\_

If a language other than English, who acted as interpreter? ☐ Agent ☐ Other: \_\_\_\_\_

Name (First, Middle, Last, Suffix) Relationship to Proposed Insured/Annuitant

## 7. ADDITIONAL DETAILS - Check the appropriate box(es) below and provide specific details in the lines below.

- ☐ No Driver's License ☐ Diagnostic Procedure or Test Within 90 Days ☐ Additional Beneficiary Information ☐ Trust is a Beneficiary  
☐ UTMA/UGMA ☐ Joint Owner Information ☐ Successor Owner ☐ Reinstatement ☐ Special Processing Instructions ☐ Other

## ILLUSTRATION (Applies only to Single Premium Variable Universal Life Insurance)

**Do not complete this section if a signed illustration is not required by law or an illustration was signed and matches the policy applied for.**

I, the Applicant, did not sign an illustration because:

- ☐ An illustration was not shown or given to me  
☐ An illustration was shown or given to me, but the policy applied for is different from the illustration  
☐ An illustration was shown to me on a screen. The displayed illustration matches the policy applied for, but no printed copy of the illustration was furnished.  
The illustration on the screen included the following personal and policy information:

Proposed Insured: \_\_\_\_\_ Age: \_\_\_\_\_ Gender: ☐ Male ☐ Female

Type of Policy: \_\_\_\_\_ Initial Death Benefit: \$ \_\_\_\_\_ Rating/Class: \_\_\_\_\_

I acknowledge that I did not sign an illustration for the reason stated above and I understand that an illustration matching the policy as issued will be provided for signature no later than at the time the policy is delivered.

## FRAUD WARNING

**Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.**

## STATEMENT OF AGREEMENT

**Those Persons Who Sign This Application Agree That:**

1. All of the statements and answers to questions which are part of the application are correctly recorded, and are complete and true to the best of the knowledge and belief of those persons who made them. Answers that are not true and complete may, subject to the policy's contestability provision, invalidate coverage.
2. No agent or medical examiner has any right to accept risks, make or change contracts, or give up NYLIAC's rights or requirements.
3. For life insurance,
  - a. "Cash Paid" with the application with respect to a new policy or additional benefit, provides a limited amount of temporary coverage for up to 90 days, if the terms and conditions of the Temporary Coverage Agreement are met.
  - b. The policy date is the date from which premiums are calculated and become due. The effective date is the date the policy is delivered and the first premium is paid. Unless temporary coverage is obtained, coverage does not begin until the effective date. If the policy date is earlier than the effective date of coverage, the policyowner pays a premium calculated beginning on that earlier policy date although coverage does not begin until the effective date. If no temporary coverage is obtained, the date that the policy is issued will be the policy date. It is further agreed and understood that interest will not be credited on the policy until the premium is received by the service office.
  - c. The Applicant has received and read a copy of the Accelerated Benefits For Terminal Illness Disclosure. Receipt of accelerated death benefits may affect eligibility for public assistance programs and may be taxable; as with all tax matters, a personal tax advisor should be consulted.
4. For annuities, the policy will not become effective unless it is delivered to the Owner while the Owner and Annuitant are living.



## TAX CERTIFICATION

Under penalties of perjury, I (as the Owner named in Section 1 or 5) certify that: (1) the Social Security or Employer ID Number shown in this application is my correct taxpayer identification number, or I am awaiting a number to be issued to me (noted as "applied for" in Section 1 or 5) AND (2) I am not subject to backup withholding because: (a) I am exempt from backup withholding; or (b) I have not been notified by the IRS that I am subject to backup withholding as a result of a failure to report all interest or dividends; or (c) the IRS has notified me that I am no longer subject to backup withholding (Cross out item 2 if the IRS has notified you that you are subject to backup withholding) and (3) I am a U.S. person (including a U.S. resident Alien).

### ACKNOWLEDGEMENT AND AUTHORIZATION (*Applies only to Single Premium Variable Universal Life Insurance*)

#### ACKNOWLEDGEMENT

I, the Proposed Insured, have been given a copy of "Information Practices Related to Underwriting Your Application" which tells how NYLIAC obtains and uses data about me. It includes the notice required by the State and Federal Fair Credit Reporting Acts and a description of MIB, Inc. (Medical Information Bureau). I know that my application cannot be processed if I do not sign the authorization below.

#### AUTHORIZATION

In this Authorization, "I" means the Proposed Insured, "the Insurer" means NYLIAC and its respective agents, employees, and representatives. In order to see if (and on what basis) I qualify for the insurance applied for or any other insurance offered by the insurers identified above, I authorize the following:

**MEDICAL INFORMATION:** Physicians or practitioners; hospitals; medical or medically related facilities; pharmacies, pharmacy benefit managers or medical information retrieval services; laboratories; insurance companies; or MIB may give to the Insurer (or any consumer reporting agency acting on its behalf) and to any of its reinsurers, at my request, copies of the record or other data that they may have about my physical and mental health, and my prescription drug history. This includes all protected health information and any health information I have previously requested be withheld from further disclosure, and including my history, their findings, diagnoses and treatment. Mental health professionals may provide their records of my diagnosis, functional status, treatment plan, symptoms, prognosis, progress to date, medication prescription and monitoring, and clinical test results.

**OTHER UNDERWRITING INFORMATION:** MIB and other insurance companies may give to the Insurer and to any of its reinsurers data about: my driving record; any criminal activity or association; hazardous sport or aviation activity; use of alcohol or drugs; any claim of eligibility for disability income benefits; and other applications for insurance.

**EXAMINATIONS AND TESTS:** The Insurer may obtain physical examinations or medical tests deemed necessary to underwrite my application. These tests (where permitted by law) may include but are not limited to, electrocardiograms, chest x-rays and tests of blood and urine to determine, among other things, exposure to causative agents of disease (for example, exposure to AIDS virus) and the presence of drugs. However, a separate notification/authorization form will be provided with respect to testing for the AIDS virus.

**INVESTIGATIVE CONSUMER REPORT:** The Insurer may obtain an investigative consumer report and may give the consumer reporting agency information concerning the amount and type of my coverage and my use, if any, of tobacco. The report may add to or confirm the types of data mentioned above. It may also contain data about: my identity; age; residence; marital status; past and present jobs (including work duties); economic conditions; driving record; personal and business reputation in the community; and mode of living; but will not include any information relating directly or indirectly to sexual orientation.

**IDENTIFICATION:** To obtain the data described above, the Insurer may give my name, address, and date and place of birth to the above persons or organization.

**RELEASE OF INFORMATION TO OTHERS:** When necessary, the Insurer may give data about me that affects my insurability to: its subsidiaries; its affiliates; its parent company; its agents and their staffs; its reinsurers; and the Insurer and its reinsurers may give such data to MIB. However, this will not be done in connection with information relating to the AIDS virus.

This Authorization may be used for a period of 24 months from the date signed below unless sooner revoked. I may revoke this Authorization at anytime by notifying the Insurer in writing. This revocation will not be effective to the extent the Insurer or any other person already has disclosed or collected information or taken other action in reliance on it. The information the Insurer obtains through this Authorization may become subject to further disclosure. For example, the Insurer may be required to provide it to an insurance regulatory or other government agency. In this case, the information may no longer be protected by the rules governing this Authorization. A photocopy of this Authorization and request form shall be as valid as the original. I know that I may request a copy of this Authorization. (Please provide a copy to me. \_\_\_\_\_ initial if requested).

### The Internal Revenue Service Does Not Require Your Consent To Any Provision Of This Document Other Than The Certifications Required To Avoid Backup Withholding.

#### SIGNATURES

By signing below, I/We understand that I/We acknowledge and agree to all of the statements, representations, and disclosures made in this application, including sections entitled Statement of Agreement, Illustration (*if applicable*), Tax Certification, and Acknowledgment and Authorization (*if applicable*). I/We accept and adopt as true all statements made by the Proposed Insured/Annuitant in this application. Benefits based on the performance of the Separate Accounts are variable and are not guaranteed as to the dollar amount.

☒ \_\_\_\_\_ Signed at \_\_\_\_\_ On \_\_\_\_\_  
Signature of the Proposed Insured/Annuitant (City, State) (mm/dd/yyyy)

☒ \_\_\_\_\_ Title if signed on behalf of Corporation, Trust, etc.  
Signature of Owner if Other than the Proposed Insured/Annuitant

☒ \_\_\_\_\_  
Signature of Applicant if Other than Proposed Insured/Annuitant or Owner

I Certify I have truly and accurately recorded all answers given to me.

☒ \_\_\_\_\_ ☒ \_\_\_\_\_  
Signature of Agent/Witness Countersigned by Licensed Resident (*if required*)

☒ \_\_\_\_\_  
Signature of Agent/Witness Countersigned Code Number



**NEW YORK LIFE** Application for Single Premium Universal Life Insurance and/or Single Premium Deferred Fixed Annuity  
New York Life Insurance and Annuity Corporation (NYLIAC) (A Delaware Corporation)

Executive Office: 51 Madison Avenue, New York, NY 10010 • Home Office: 200 Continental Drive, Suite 306, Newark, DE 19713

**1. PROPOSED INSURED/ANNUITANT INFORMATION**

First Name	Middle Name	Last Name	Suffix	<input type="checkbox"/> Male <input type="checkbox"/> Female	Date of Birth (mm/dd/yyyy)
Residence: Street	City	State	Country	Zip	Home Telephone (Evening) Business Telephone (Day)
<input type="checkbox"/> Social Security No. or <input type="checkbox"/> Tax I.D. No. <input type="checkbox"/> Exempt <input type="checkbox"/> Applied for					
Country of Citizenship	Country of Birth	State of Birth	How Long Living in the USA? <input type="checkbox"/> Since Birth or _____ Years _____ Months		
Immigration Visa or Work Authorization: (If other than a US citizen) Type Number		Expiration Month Year	Occupation		
Employer Name:	Street	City	State	Country	Zip

*If the Owner, Joint Owner, Applicant, or Payer is not the Proposed Insured/Annuitant, please provide the appropriate additional information in Section 5.*

**2. MEDICAL AND PERSONAL INFORMATION (Applies only to Single Premium Universal Life Insurance)**

- A. Has the Proposed Insured used tobacco, nicotine, or any nicotine substitution product in any form in the last twelve (12) months? . . . . . ☐ Yes ☐ No
- B. In the last 90 days, has the Proposed Insured been recommended by a physician or other medical practitioner to undergo diagnostic procedures or tests for any symptoms, illnesses or other conditions? (If "Yes," please provide additional information in Section 7) . . . . . ☐ Yes ☐ No
- C. In the last two (2) years, has the Proposed Insured been admitted to a hospital or other medical facility for a medical illness or major surgical procedure? . . . . . ☐ Yes ☐ No
- D. In the last five (5) years, has the Proposed Insured been diagnosed by a member of the medical profession or tested positive for Human Immunodeficiency Virus (AIDS virus) or Acquired Immune Deficiency Syndrome (AIDS)? . . . . . ☐ Yes ☐ No
- E. In the last five (5) years, has the Proposed Insured been diagnosed, treated, tested positive for or been given medical advice by a member of the medical profession for any of the conditions below? (If "Yes," circle all applicable conditions)

1) Heart attack, chest pains, or heart disorder, angina, heart surgery, or angioplasty	<input type="checkbox"/> Yes <input type="checkbox"/> No	7) Pancreatitis, hepatitis, cirrhosis, kidney failure, or a condition requiring dialysis	<input type="checkbox"/> Yes <input type="checkbox"/> No
2) Stroke or transient ischemic attack (TIA)	<input type="checkbox"/> Yes <input type="checkbox"/> No	8) Anemia requiring blood transfusions	<input type="checkbox"/> Yes <input type="checkbox"/> No
3) Vascular disease (peripheral vascular disease, aneurysm, artery blockage)	<input type="checkbox"/> Yes <input type="checkbox"/> No	9) Any major psychiatric or mental condition requiring hospitalization	<input type="checkbox"/> Yes <input type="checkbox"/> No
4) Diabetes requiring insulin treatment	<input type="checkbox"/> Yes <input type="checkbox"/> No	10) Drug or alcohol abuse	<input type="checkbox"/> Yes <input type="checkbox"/> No
5) Any form of malignant cancer or tumor, leukemia, Hodgkin's disease, or lymphoma requiring chemo/radiation therapy	<input type="checkbox"/> Yes <input type="checkbox"/> No	11) Unexplained weight loss exceeding twenty (20) pounds	<input type="checkbox"/> Yes <input type="checkbox"/> No
6) Chronic bronchitis, emphysema (COPD), or any condition requiring oxygen therapy	<input type="checkbox"/> Yes <input type="checkbox"/> No	12) Muscular dystrophy, ALS, lupus, multiple sclerosis, seizures, Alzheimer's disease or other neurological disorder	<input type="checkbox"/> Yes <input type="checkbox"/> No

**3. PRODUCT SELECTION AND PREMIUM – If "No" is answered in Section 2 for Questions C and D, and all conditions listed in Question E, one or both products may be selected. If "Yes" is answered in Section 2 for Questions C or D, or any condition listed in Question E, only a Single Premium Deferred Fixed Annuity may be selected. If applicable, make check payable to NYLIAC.**

☐ **Single Premium Universal Life Insurance** (If "Yes" is answered to Question B in Section 2 above, do not collect life insurance premium. Temporary Coverage is not available.)

Face Amount: \$ \_\_\_\_\_ Premium: \$ \_\_\_\_\_ Premium Paid: \$ \_\_\_\_\_ (Optional. If paid, must be equal to full premium.)

☐ **Single Premium Deferred Fixed Annuity** (Annuity commencement at the later of age 90 or 10 years for all products. Do not use for Qualified Plans)  
(Choose ONE annuity product below. All products may not be available in all jurisdictions.)

☐ New York Life Enhanced Fixed Annuity (EFA)\*

Surrender Charge Period (check one box for EFA only)

☐ 6 Years ☐ 8 Years

\*During the initial Interest Rate Guarantee Period, a higher interest rate will be credited to policies issued with an 8-Year Surrender Charge period.

☐ New York Life Preferred Fixed Annuity (PFA)

☐ New York Life Optimal Fixed Annuity (OFA)

☐ New York Life Select 5 Fixed Annuity (S5FA)

☐ Other: \_\_\_\_\_

Client Profile and Policy Disclosure Form **required** with all Single Premium Deferred Fixed Annuity applications.



### 3. PRODUCT SELECTION AND PREMIUM (Continued)

#### Single Premium (EFA, PFA, OFA, & S5FA)

\$ \_\_\_\_\_ (indicate total estimated amount including cash with application and anticipated transfer/exchange amounts)

Premium Paid \$ \_\_\_\_\_

**Initial Interest Rate Guarantee Period** (5 Years only for Select 5. All others check one box below.)

☐ 1 Year (EFA, PFA, OFA)    ☐ 3 Years (EFA, PFA, OFA)    ☐ 6 Years (EFA)    ☐ 7 Years (PFA)

☐ Other: \_\_\_\_\_

### 4. BENEFICIARY(IES)

- If more than one Beneficiary is named, indicate the class and percentage for each. Each class for each product must total 100%.
- If applicable, use Section 7, "Additional Details," to provide additional Beneficiary information.

#### Single Premium Universal Life Insurance Beneficiaries

(if applicable)

☐ **Trust** (Provide details in Section 7)

☐ **UTMA/UGMA** (Provide details in Section 7)

##### Class

**Primary** \_\_\_\_\_  %  
Name (First, Middle, Last, Suffix) Percentage

☐ **Primary** \_\_\_\_\_  
Relationship to Proposed Insured

☐ **Contingent** \_\_\_\_\_  %  
Name (First, Middle, Last, Suffix) Percentage

\_\_\_\_\_  
Relationship to Proposed Insured

#### Single Premium Deferred Fixed Annuity Beneficiaries (if applicable)

☐ **Same Beneficiary designations for both products**

☐ **Surviving Spouse Under Joint Spousal Ownership**

☐ **Trust** (Provide details in Section 7)

☐ **UTMA/UGMA** (Provide details in Section 7)

##### Class

**Primary** \_\_\_\_\_  %  
Name (First, Middle, Last, Suffix) Percentage

☐ **Primary** \_\_\_\_\_  
Relationship to Proposed Annuitant

☐ **Contingent** \_\_\_\_\_  %  
Name (First, Middle, Last, Suffix) Percentage

\_\_\_\_\_  
Relationship to Proposed Annuitant

### 5. OTHER PARTY INFORMATION

#### A. Owner Information (if not the Proposed Insured/Annuitant)

☐ Individual    ☐ Trust    ☐ Corp. If Individual, provide:

Owner (First, Middle, Last, Suffix) \_\_\_\_\_ Birth Date (mm/dd/yyyy) \_\_\_\_\_ ☐ Male    ☐ Female    ☐ SSN or ☐ Tax I.D. No. ☐ Exempt ☐ Applied for

Residence (Street, City, State, Country, Zip Code) \_\_\_\_\_ Home Telephone (Evening) \_\_\_\_\_ Business Telephone (Day) \_\_\_\_\_

Country of Citizenship \_\_\_\_\_ Country of Birth \_\_\_\_\_ State of Birth \_\_\_\_\_ Relationship to Proposed Insured/Annuitant \_\_\_\_\_

If not a US citizen, type of immigration visa or work authorization: \_\_\_\_\_ Number: \_\_\_\_\_ Expiration (mm/yyyy): \_\_\_\_\_

If Trust: Name of Trust \_\_\_\_\_ Date of Trust \_\_\_\_\_ State Where Trust Established \_\_\_\_\_

Name of Trustee(s) \_\_\_\_\_ Relationship of Trustee(s) to Proposed Insured/Annuitant \_\_\_\_\_

Trust Beneficiary(ies) \_\_\_\_\_ Relationship of Trust Beneficiary(ies) to Proposed Insured/Annuitant \_\_\_\_\_

Is the trust a grantor trust? ☐ Yes    ☐ No    If "Yes" and the grantor is an individual: \_\_\_\_\_  
Grantor's Name (First, Middle, Last, Suffix)

If joint ownership: The joint owner ☐ **is** ☐ **is not** the Proposed Insured/Annuitant. (If not the Proposed Insured/Annuitant, provide information for joint owner in Section 7, "Additional Details." Unless otherwise specified in Section 7, ownership will be joint with right of survivorship.)

#### B. Applicant Information (if not the Proposed Insured/Annuitant or Owner)

Name (First, Middle, Last, Suffix) \_\_\_\_\_ Birth Date (mm/dd/yyyy) \_\_\_\_\_ ☐ Male    ☐ Female    ☐ SSN or ☐ Tax I.D. No. ☐ Exempt ☐ Applied for

Residence (Street, City, State, Country, Zip Code) \_\_\_\_\_ Relationship to Proposed Insured/Annuitant \_\_\_\_\_



## 5. OTHER PARTY INFORMATION (Continued)

### C. Payer Information (if not the Proposed Insured/Annuitant)

Same as ☐ Owner ☐ Applicant

Name (First, Middle, Last, Suffix)	Birth Date (mm/dd/yyyy)	<input type="checkbox"/> Male <input type="checkbox"/> Female	<input type="checkbox"/> SSN or <input type="checkbox"/> Tax I.D. No. <input type="checkbox"/> Exempt <input type="checkbox"/> Applied for
Residence (Street, City, State, Country, Zip Code)			Relationship to Proposed Insured/Annuitant
Relationship to Owner (if other than Proposed Insured/Annuitant)			

### D. Secondary Addressee - Owner may designate a secondary addressee to receive notice of potential lapse of coverage.

Name (First, Middle, Last, Suffix)	Residence (Street, City, State, Country, Zip Code)
------------------------------------	----------------------------------------------------

## 6. SALES INTERVIEW

In which language and dialect(s) was the sales interview conducted? Language: \_\_\_\_\_ Dialect(s): \_\_\_\_\_

If a language other than English, who acted as interpreter? ☐ Agent ☐ Other: \_\_\_\_\_  
Name (First, Middle, Last, Suffix) Relationship to Proposed Insured/Annuitant

## 7. ADDITIONAL DETAILS - Check the appropriate box(es) below and provide specific details in the lines below.

- ☐ No Driver's License ☐ Diagnostic Procedure or Test Within 90 Days ☐ Additional Beneficiary Information ☐ Trust is a Beneficiary  
☐ UTMA/UGMA ☐ Joint Owner Information ☐ Successor Owner ☐ Reinstatement ☐ Special Processing Instructions ☐ Other

## ILLUSTRATION (Applies only to Single Premium Universal Life Insurance)

**Do not complete this section if a signed illustration is not required by law or an illustration was signed and matches the policy applied for.**

I, the Applicant, did not sign an illustration because:

- ☐ An illustration was not shown or given to me  
☐ An illustration was shown or given to me, but the policy applied for is different from the illustration  
☐ An illustration was shown to me on a screen. The displayed illustration matches the policy applied for, but no printed copy of the illustration was furnished.  
The illustration on the screen included the following personal and policy information:

Proposed Insured: \_\_\_\_\_ Age: \_\_\_\_\_ Gender: ☐ Male ☐ Female

Type of Policy: \_\_\_\_\_ Initial Death Benefit: \$ \_\_\_\_\_ Rating/Class: \_\_\_\_\_

I acknowledge that I did not sign an illustration for the reason stated above and I understand that an illustration matching the policy as issued will be provided for signature no later than at the time the policy is delivered.

## FRAUD WARNING

**Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.**

## STATEMENT OF AGREEMENT

**Those Persons Who Sign This Application Agree That:**

1. All of the statements and answers to questions which are part of the application are correctly recorded, and are complete and true to the best of the knowledge and belief of those persons who made them. Answers that are not true and complete may, subject to the policy's contestability provision, invalidate coverage.
2. No agent or medical examiner has any right to accept risks, make or change contracts, or give up NYLIAC's rights or requirements.
3. For life insurance,
  - a. "Cash Paid" with the application with respect to a new policy or additional benefit, provides a limited amount of temporary coverage for up to 90 days, if the terms and conditions of the Temporary Coverage Agreement are met.
  - b. The policy date is the date from which premiums are calculated and become due. The effective date is the date the policy is delivered and the first premium is paid. Unless temporary coverage is obtained, coverage does not begin until the effective date. If the policy date is earlier than the effective date of coverage, the policyowner pays a premium calculated beginning on that earlier policy date although coverage does not begin until the effective date. If no temporary coverage is obtained, the date that the policy is issued will be the policy date. It is further agreed and understood that interest will not be credited on the policy until the premium is received by the service office.
  - c. The Applicant has received and read a copy of the Accelerated Benefits For Terminal Illness Disclosure. Receipt of accelerated death benefits may affect eligibility for public assistance programs and may be taxable; as with all tax matters, a personal tax advisor should be consulted.
4. For annuities, the policy will not become effective unless it is delivered to the Owner while the Owner and Annuitant are living.

**CUSTOMER COPY**

THIS PAGE INTENTIONALLY LEFT BLANK



## 5. OTHER PARTY INFORMATION (Continued)

### C. Payer Information (if not the Proposed Insured/Annuitant)

Same as ☐ Owner ☐ Applicant

Name (First, Middle, Last, Suffix)	Birth Date (mm/dd/yyyy)	<input type="checkbox"/> Male <input type="checkbox"/> Female	<input type="checkbox"/> SSN or <input type="checkbox"/> Tax I.D. No. <input type="checkbox"/> Exempt <input type="checkbox"/> Applied for
Residence (Street, City, State, Country, Zip Code)			Relationship to Proposed Insured/Annuitant
Relationship to Owner (if other than Proposed Insured/Annuitant)			

### D. Secondary Addressee - Owner may designate a secondary addressee to receive notice of potential lapse of coverage.

Name (First, Middle, Last, Suffix)	Residence (Street, City, State, Country, Zip Code)
------------------------------------	----------------------------------------------------

## 6. SALES INTERVIEW

In which language and dialect(s) was the sales interview conducted? Language: \_\_\_\_\_ Dialect(s): \_\_\_\_\_

If a language other than English, who acted as interpreter? ☐ Agent ☐ Other: \_\_\_\_\_  
Name (First, Middle, Last, Suffix) Relationship to Proposed Insured/Annuitant

## 7. ADDITIONAL DETAILS - Check the appropriate box(es) below and provide specific details in the lines below.

☐ No Driver's License ☐ Diagnostic Procedure or Test Within 90 Days ☐ Additional Beneficiary Information ☐ Trust is a Beneficiary  
☐ UTMA/UGMA ☐ Joint Owner Information ☐ Successor Owner ☐ Reinstatement ☐ Special Processing Instructions ☐ Other

## ILLUSTRATION (Applies only to Single Premium Universal Life Insurance)

**Do not complete this section if a signed illustration is not required by law or an illustration was signed and matches the policy applied for.**

I, the Applicant, did not sign an illustration because:

- ☐ An illustration was not shown or given to me
- ☐ An illustration was shown or given to me, but the policy applied for is different from the illustration
- ☐ An illustration was shown to me on a screen. The displayed illustration matches the policy applied for, but no printed copy of the illustration was furnished.  
The illustration on the screen included the following personal and policy information:

Proposed Insured: \_\_\_\_\_ Age: \_\_\_\_\_ Gender: ☐ Male ☐ Female

Type of Policy: \_\_\_\_\_ Initial Death Benefit: \$ \_\_\_\_\_ Rating/Class: \_\_\_\_\_

I acknowledge that I did not sign an illustration for the reason stated above and I understand that an illustration matching the policy as issued will be provided for signature no later than at the time the policy is delivered.

## FRAUD WARNING

**Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.**

## STATEMENT OF AGREEMENT

### Those Persons Who Sign This Application Agree That:

1. All of the statements and answers to questions which are part of the application are correctly recorded, and are complete and true to the best of the knowledge and belief of those persons who made them. Answers that are not true and complete may, subject to the policy's contestability provision, invalidate coverage.
2. No agent or medical examiner has any right to accept risks, make or change contracts, or give up NYLIAC's rights or requirements.
3. For life insurance,
  - a. "Cash Paid" with the application with respect to a new policy or additional benefit, provides a limited amount of temporary coverage for up to 90 days, if the terms and conditions of the Temporary Coverage Agreement are met.
  - b. The policy date is the date from which premiums are calculated and become due. The effective date is the date the policy is delivered and the first premium is paid. Unless temporary coverage is obtained, coverage does not begin until the effective date. If the policy date is earlier than the effective date of coverage, the policyowner pays a premium calculated beginning on that earlier policy date although coverage does not begin until the effective date. If no temporary coverage is obtained, the date that the policy is issued will be the policy date. It is further agreed and understood that interest will not be credited on the policy until the premium is received by the service office.
  - c. The Applicant has received and read a copy of the Accelerated Benefits For Terminal Illness Disclosure. Receipt of accelerated death benefits may affect eligibility for public assistance programs and may be taxable; as with all tax matters, a personal tax advisor should be consulted.
4. For annuities, the policy will not become effective unless it is delivered to the Owner while the Owner and Annuitant are living.



## TAX CERTIFICATION

Under penalties of perjury, I (as the Owner named in Section 1 or 5) certify that: (1) the Social Security or Employer ID Number shown in this application is my correct taxpayer identification number, or I am awaiting a number to be issued to me (noted as "applied for" in Section 1 or 5) AND (2) I am not subject to backup withholding because: (a) I am exempt from backup withholding; or (b) I have not been notified by the IRS that I am subject to backup withholding as a result of a failure to report all interest or dividends; or (c) the IRS has notified me that I am no longer subject to backup withholding (Cross out item 2 if the IRS has notified you that you are subject to backup withholding) and (3) I am a U.S. person (including a U.S. resident Alien).

### ACKNOWLEDGEMENT AND AUTHORIZATION (*Applies only to Single Premium Universal Life Insurance*)

#### ACKNOWLEDGEMENT

I, the Proposed Insured, have been given a copy of "Information Practices Related to Underwriting Your Application" which tells how NYLIAC obtains and uses data about me. It includes the notice required by the State and Federal Fair Credit Reporting Acts and a description of MIB, Inc. (Medical Information Bureau). I know that my application cannot be processed if I do not sign the authorization below.

#### AUTHORIZATION

In this Authorization, "I" means the Proposed Insured, "the Insurer" means NYLIAC and its respective agents, employees, and representatives. In order to see if (and on what basis) I qualify for the insurance applied for or any other insurance offered by the insurers identified above, I authorize the following:

**MEDICAL INFORMATION:** Physicians or practitioners; hospitals; medical or medically related facilities; pharmacies, pharmacy benefit managers or medical information retrieval services; laboratories; insurance companies; or MIB may give to the Insurer (or any consumer reporting agency acting on its behalf) and to any of its reinsurers, at my request, copies of the record or other data that they may have about my physical and mental health, and my prescription drug history. This includes all protected health information and any health information I have previously requested be withheld from further disclosure, and including my history, their findings, diagnoses and treatment. Mental health professionals may provide their records of my diagnosis, functional status, treatment plan, symptoms, prognosis, progress to date, medication prescription and monitoring, and clinical test results.

**OTHER UNDERWRITING INFORMATION:** MIB and other insurance companies may give to the Insurer and to any of its reinsurers data about: my driving record; any criminal activity or association; hazardous sport or aviation activity; use of alcohol or drugs; any claim of eligibility for disability income benefits; and other applications for insurance.

**EXAMINATIONS AND TESTS:** The Insurer may obtain physical examinations or medical tests deemed necessary to underwrite my application. These tests (where permitted by law) may include but are not limited to, electrocardiograms, chest x-rays and tests of blood and urine to determine, among other things, exposure to causative agents of disease (for example, exposure to AIDS virus) and the presence of drugs. However, a separate notification/authorization form will be provided with respect to testing for the AIDS virus.

**INVESTIGATIVE CONSUMER REPORT:** The Insurer may obtain an investigative consumer report and may give the consumer reporting agency information concerning the amount and type of my coverage and my use, if any, of tobacco. The report may add to or confirm the types of data mentioned above. It may also contain data about: my identity; age; residence; marital status; past and present jobs (including work duties); economic conditions; driving record; personal and business reputation in the community; and mode of living; but will not include any information relating directly or indirectly to sexual orientation.

**IDENTIFICATION:** To obtain the data described above, the Insurer may give my name, address, and date and place of birth to the above persons or organization.

**RELEASE OF INFORMATION TO OTHERS:** When necessary, the Insurer may give data about me that affects my insurability to: its subsidiaries; its affiliates; its parent company; its agents and their staffs; its reinsurers; and the Insurer and its reinsurers may give such data to MIB. However, this will not be done in connection with information relating to the AIDS virus.

This Authorization may be used for a period of 24 months from the date signed below unless sooner revoked. I may revoke this Authorization at anytime by notifying the Insurer in writing. This revocation will not be effective to the extent the Insurer or any other person already has disclosed or collected information or taken other action in reliance on it. The information the Insurer obtains through this Authorization may become subject to further disclosure. For example, the Insurer may be required to provide it to an insurance regulatory or other government agency. In this case, the information may no longer be protected by the rules governing this Authorization. A photocopy of this Authorization and request form shall be as valid as the original. I know that I may request a copy of this Authorization. (Please provide a copy to me. \_\_\_\_\_ initial if requested).

### The Internal Revenue Service Does Not Require Your Consent To Any Provision Of This Document Other Than The Certifications Required To Avoid Backup Withholding.

#### SIGNATURES

By signing below, I/We understand that I/We acknowledge and agree to all of the statements, representations, and disclosures made in this application, including sections entitled Statement of Agreement, Illustration (*if applicable*), Tax Certification, and Acknowledgment and Authorization (*if applicable*). I/We accept and adopt as true all statements made by the Proposed Insured/Annuitant in this application.

**X** \_\_\_\_\_ Signed at \_\_\_\_\_ On \_\_\_\_\_  
Signature of the Proposed Insured/Annuitant (City, State) (mm/dd/yyyy)

**X** \_\_\_\_\_ Title if signed on behalf of Corporation, Trust, etc.  
Signature of Owner if Other than the Proposed Insured/Annuitant

**X** \_\_\_\_\_  
Signature of Applicant if Other than Proposed Insured/Annuitant or Owner

I Certify I have truly and accurately recorded all answers given to me.

**X** \_\_\_\_\_ **X** \_\_\_\_\_  
Signature of Agent/Witness Countersigned by Licensed Resident (*if required*)

**X** \_\_\_\_\_  
Signature of Agent/Witness Countersigned Code Number



**NEW YORK LIFE INSURANCE AND ANNUITY CORPORATION** (A Delaware Corporation)

Executive Office: 51 Madison Avenue, New York, NY 10010 • Home Office: 200 Continental Drive, Suite 306, Newark, DE 19713

Dear Applicant:

Congratulations! By applying for a Single Premium Variable Universal Life Insurance policy issued by New York Life Insurance and Annuity Corporation, you are taking an important step toward leaving a larger legacy for your loved ones. Since you have provided cash or a check with your life insurance application (the "Application"), we are pleased to provide you with the terms of temporary insurance coverage that may be in effect while we process the Application. Please note that temporary life insurance coverage is not available for annuities.

**Temporary Coverage Agreement (the "Agreement")**

NO INSURANCE WILL TAKE EFFECT EXCEPT AS DESCRIBED BELOW. This Agreement is not transferable.

**When Temporary Insurance Starts**

If payment has been accepted by New York Life Insurance and Annuity Corporation ("NYLIAC," "we," "us," "our") for a life insurance policy, temporary insurance under this Agreement will start on the date the Application is signed if: (1) the Application has been completed and the Applicant has answered "No" in Section 2 of the Application for Questions B, C, D, and all of the conditions listed in Question E; and (2) the Application has been signed by all required parties, including the Applicant, the Proposed Insured (if other than the Applicant), and the Agent, on or before the date of this Agreement. The sum paid in exchange for this Agreement must be the full single premium payment for the face amount of life insurance.

**When Temporary Insurance Will End**

Temporary insurance under this Agreement will end on the earliest of the dates below:

1. 90 days after the temporary insurance under this Agreement starts;
2. The date of our notice to the Applicant that the life insurance application has been declined;
3. The date of the Applicant's written request for a full refund of the payment, in which event all coverage will be void from the start;
4. The date the life insurance policy is put in force, at which point all coverage shall be provided by the policy.

**Amount of Insurance**

If temporary insurance under this Agreement is in effect, it will have the same benefits, provisions, and limitations and be for the same amount of life insurance proceeds as the life insurance policy applied for. However, we will provide no more than a combined total of \$1,000,000 of temporary life insurance for all benefits (including Accidental Death Benefit and any other benefits) on the Proposed Insured under this and any other receipt.

**Conditions Under Which There Is No Coverage**

No insurance starts under this Agreement if:

1. No payment is received or if the bank does not honor a check or draft given as payment;
2. There is misrepresentation material to the underwriter's acceptance of the risk in the answers in the Application;
3. The Proposed Insured, while sane or insane, commits suicide or intentionally self-inflicts injury;
4. We are prohibited by any state or federal law, regulation or order from doing business with or participating in a transaction involving any person identified as the Proposed Insured, Owner, Applicant, Payor, or Beneficiary in the Application for the life insurance policy;
5. In Section 2 of the Application, Questions B, C, or D, or any of the conditions listed in Question E, is answered "Yes" or is left blank, or answered falsely;
6. Reinstatement of a policy is being applied for; or
7. A policy or benefit is being applied for under the terms of a contractual conversion privilege.

**Refund of Payment**

If temporary life insurance is not payable under this Agreement (except for the reason that the policy has been put in force), we will refund the payment with respect to the life insurance policy.

**Limitation of Authority**

**No Agent or medical examiner has any right to accept any risk, make or change contracts, give up any of our rights or requirements, or change the provisions of this Agreement.**



**NEW YORK LIFE INSURANCE AND ANNUITY CORPORATION**

Received from \_\_\_\_\_ on \_\_\_\_/\_\_\_\_/\_\_\_\_ the  
sum of \_\_\_\_\_ Dollars (\$\_\_\_\_\_). This amount  
is the sum of the Premium Paid amounts specified in Question 3 of the Application bearing the same date and number as this receipt.

Any check tendered should be payable to NYLIAC rather than to the Agent. The payee should not be left blank. Any check received will be subject to collection. This receipt is not transferable.

Receipt No. **XXXXXXXX**

**X** \_\_\_\_\_  
Agent Signature (Agent must sign)

**CUSTOMER COPY**

**THIS PAGE DOES NOT PRINT**



**NEW YORK LIFE INSURANCE AND ANNUITY CORPORATION** (A Delaware Corporation)

Executive Office: 51 Madison Avenue, New York, NY 10010 • Home Office: 200 Continental Drive, Suite 306, Newark, DE 19713

Dear Applicant:

Congratulations! By applying for a Single Premium Variable Universal Life Insurance policy issued by New York Life Insurance and Annuity Corporation, you are taking an important step toward leaving a larger legacy for your loved ones. Since you have provided cash or a check with your life insurance application (the "Application"), we are pleased to provide you with the terms of temporary insurance coverage that may be in effect while we process the Application. Please note that temporary life insurance coverage is not available for annuities.

**Temporary Coverage Agreement (the "Agreement")**

NO INSURANCE WILL TAKE EFFECT EXCEPT AS DESCRIBED BELOW. This Agreement is not transferable.

**When Temporary Insurance Starts**

If payment has been accepted by New York Life Insurance and Annuity Corporation ("NYLIAC," "we," "us," "our") for a life insurance policy, temporary insurance under this Agreement will start on the date the Application is signed if: (1) the Application has been completed and the Applicant has answered "No" in Section 2 of the Application for Questions B, C, D, and all of the conditions listed in Question E; and (2) the Application has been signed by all required parties, including the Applicant, the Proposed Insured (if other than the Applicant), and the Agent, on or before the date of this Agreement. The sum paid in exchange for this Agreement must be the full single premium payment for the face amount of life insurance.

**When Temporary Insurance Will End**

Temporary insurance under this Agreement will end on the earliest of the dates below:

1. 90 days after the temporary insurance under this Agreement starts;
2. The date of our notice to the Applicant that the life insurance application has been declined;
3. The date of the Applicant's written request for a full refund of the payment, in which event all coverage will be void from the start;
4. The date the life insurance policy is put in force, at which point all coverage shall be provided by the policy.

**Amount of Insurance**

If temporary insurance under this Agreement is in effect, it will have the same benefits, provisions, and limitations and be for the same amount of life insurance proceeds as the life insurance policy applied for. However, we will provide no more than a combined total of \$1,000,000 of temporary life insurance for all benefits (including Accidental Death Benefit and any other benefits) on the Proposed Insured under this and any other receipt.

**Conditions Under Which There Is No Coverage**

No insurance starts under this Agreement if:

1. No payment is received or if the bank does not honor a check or draft given as payment;
2. There is misrepresentation material to the underwriter's acceptance of the risk in the answers in the Application;
3. The Proposed Insured, while sane or insane, commits suicide or intentionally self-inflicts injury;
4. We are prohibited by any state or federal law, regulation or order from doing business with or participating in a transaction involving any person identified as the Proposed Insured, Owner, Applicant, Payor, or Beneficiary in the Application for the life insurance policy;
5. In Section 2 of the Application, Questions B, C, or D, or any of the conditions listed in Question E, is answered "Yes" or is left blank, or answered falsely;
6. Reinstatement of a policy is being applied for; or
7. A policy or benefit is being applied for under the terms of a contractual conversion privilege.

**Refund of Payment**

If temporary life insurance is not payable under this Agreement (except for the reason that the policy has been put in force), we will refund the payment with respect to the life insurance policy.

**Limitation of Authority**

**No Agent or medical examiner has any right to accept any risk, make or change contracts, give up any of our rights or requirements, or change the provisions of this Agreement.**



**NEW YORK LIFE INSURANCE AND ANNUITY CORPORATION**

Received from \_\_\_\_\_ on \_\_\_\_/\_\_\_\_/\_\_\_\_ the sum of \_\_\_\_\_ Dollars (\$ \_\_\_\_\_). This amount is the sum of the Premium Paid amounts specified in Question 3 of the Application bearing the same date and number as this receipt.

Any check tendered should be payable to NYLIAC rather than to the Agent. The payee should not be left blank. Any check received will be subject to collection. This receipt is not transferable.

Receipt No. **XXXXXXXX**

**X** \_\_\_\_\_  
Agent Signature (Agent must sign)

**THIS PAGE DOES NOT PRINT**



**NEW YORK LIFE INSURANCE AND ANNUITY CORPORATION** (A Delaware Corporation)

Executive Office: 51 Madison Avenue, New York, NY 10010 • Home Office: 200 Continental Drive, Suite 306, Newark, DE 19713

Dear Applicant:

Congratulations! By applying for an Instant Legacy Single Premium Universal Life Insurance policy issued by New York Life Insurance and Annuity Corporation, you are taking an important step toward leaving a larger legacy for your loved ones. Since you have provided cash or a check with your life insurance application (the "Application"), we are pleased to provide you with the terms of temporary insurance coverage that may be in effect while we process the Application. Please note that temporary life insurance coverage is not available for annuities.

**Temporary Coverage Agreement (the "Agreement")**

NO INSURANCE WILL TAKE EFFECT EXCEPT AS DESCRIBED BELOW. This Agreement is not transferable.

**When Temporary Insurance Starts**

If payment has been accepted by New York Life Insurance and Annuity Corporation ("NYLIAC," "we," "us," "our") for a life insurance policy, temporary insurance under this Agreement will start on the date the Application is signed if: (1) the Application has been completed and the Applicant has answered "No" in Section 2 of the Application for Questions B, C, D, and all of the conditions listed in Question E; and (2) the Application has been signed by all required parties, including the Applicant, the Proposed Insured (if other than the Applicant), and the Agent, on or before the date of this Agreement. The sum paid in exchange for this Agreement must be the full single premium payment for the face amount of life insurance.

**When Temporary Insurance Will End**

Temporary insurance under this Agreement will end on the earliest of the dates below:

1. 90 days after the temporary insurance under this Agreement starts;
2. The date of our notice to the Applicant that the life insurance application has been declined;
3. The date of the Applicant's written request for a full refund of the payment, in which event all coverage will be void from the start;
4. The date the life insurance policy is put in force, at which point all coverage shall be provided by the policy.

**Amount of Insurance**

If temporary insurance under this Agreement is in effect, it will have the same benefits, provisions, and limitations and be for the same amount of life insurance proceeds as the life insurance policy applied for. However, we will provide no more than a combined total of \$1,000,000 of temporary life insurance for all benefits (including Accidental Death Benefit and any other benefits) on the Proposed Insured under this and any other receipt.

**Conditions Under Which There Is No Coverage**

No insurance starts under this Agreement if:

1. No payment is received or if the bank does not honor a check or draft given as payment;
2. There is misrepresentation material to the underwriter's acceptance of the risk in the answers in the Application;
3. The Proposed Insured, while sane or insane, commits suicide or intentionally self-inflicts injury;
4. We are prohibited by any state or federal law, regulation or order from doing business with or participating in a transaction involving any person identified as the Proposed Insured, Owner, Applicant, Payor, or Beneficiary in the Application for the life insurance policy;
5. In Section 2 of the Application, Questions B, C, or D, or any of the conditions listed in Question E, is answered "Yes" or is left blank, or answered falsely;
6. Reinstatement of a policy is being applied for; or
7. A policy or benefit is being applied for under the terms of a contractual conversion privilege.

**Refund of Payment**

If temporary life insurance is not payable under this Agreement (except for the reason that the policy has been put in force), we will refund the payment with respect to the life insurance policy.

**Limitation of Authority**

**No Agent or medical examiner has any right to accept any risk, make or change contracts, give up any of our rights or requirements, or change the provisions of this Agreement.**



**NEW YORK LIFE INSURANCE AND ANNUITY CORPORATION**

Received from \_\_\_\_\_ on \_\_\_\_/\_\_\_\_/\_\_\_\_ the sum of \_\_\_\_\_ Dollars (\$ \_\_\_\_\_). This amount is the sum of the Premium Paid amounts specified in Question 3 of the Application bearing the same date and number as this receipt.

Any check tendered should be payable to NYLIAC rather than to the Agent. The payee should not be left blank. Any check received will be subject to collection. This receipt is not transferable.

Receipt No. **XXXXXXXX**

**X** \_\_\_\_\_

Agent Signature (Agent must sign)

**CUSTOMER COPY**

**THIS PAGE DOES NOT PRINT**



**NEW YORK LIFE INSURANCE AND ANNUITY CORPORATION** (A Delaware Corporation)

Executive Office: 51 Madison Avenue, New York, NY 10010 • Home Office: 200 Continental Drive, Suite 306, Newark, DE 19713

Dear Applicant:

Congratulations! By applying for an Instant Legacy Single Premium Universal Life Insurance policy issued by New York Life Insurance and Annuity Corporation, you are taking an important step toward leaving a larger legacy for your loved ones. Since you have provided cash or a check with your life insurance application (the "Application"), we are pleased to provide you with the terms of temporary insurance coverage that may be in effect while we process the Application. Please note that temporary life insurance coverage is not available for annuities.

**Temporary Coverage Agreement (the "Agreement")**

NO INSURANCE WILL TAKE EFFECT EXCEPT AS DESCRIBED BELOW. This Agreement is not transferable.

**When Temporary Insurance Starts**

If payment has been accepted by New York Life Insurance and Annuity Corporation ("NYLIAC," "we," "us," "our") for a life insurance policy, temporary insurance under this Agreement will start on the date the Application is signed if: (1) the Application has been completed and the Applicant has answered "No" in Section 2 of the Application for Questions B, C, D, and all of the conditions listed in Question E; and (2) the Application has been signed by all required parties, including the Applicant, the Proposed Insured (if other than the Applicant), and the Agent, on or before the date of this Agreement. The sum paid in exchange for this Agreement must be the full single premium payment for the face amount of life insurance.

**When Temporary Insurance Will End**

Temporary insurance under this Agreement will end on the earliest of the dates below:

1. 90 days after the temporary insurance under this Agreement starts;
2. The date of our notice to the Applicant that the life insurance application has been declined;
3. The date of the Applicant's written request for a full refund of the payment, in which event all coverage will be void from the start;
4. The date the life insurance policy is put in force, at which point all coverage shall be provided by the policy.

**Amount of Insurance**

If temporary insurance under this Agreement is in effect, it will have the same benefits, provisions, and limitations and be for the same amount of life insurance proceeds as the life insurance policy applied for. However, we will provide no more than a combined total of \$1,000,000 of temporary life insurance for all benefits (including Accidental Death Benefit and any other benefits) on the Proposed Insured under this and any other receipt.

**Conditions Under Which There Is No Coverage**

No insurance starts under this Agreement if:

1. No payment is received or if the bank does not honor a check or draft given as payment;
2. There is misrepresentation material to the underwriter's acceptance of the risk in the answers in the Application;
3. The Proposed Insured, while sane or insane, commits suicide or intentionally self-inflicts injury;
4. We are prohibited by any state or federal law, regulation or order from doing business with or participating in a transaction involving any person identified as the Proposed Insured, Owner, Applicant, Payor, or Beneficiary in the Application for the life insurance policy;
5. In Section 2 of the Application, Questions B, C, or D, or any of the conditions listed in Question E, is answered "Yes" or is left blank, or answered falsely;
6. Reinstatement of a policy is being applied for; or
7. A policy or benefit is being applied for under the terms of a contractual conversion privilege.

**Refund of Payment**

If temporary life insurance is not payable under this Agreement (except for the reason that the policy has been put in force), we will refund the payment with respect to the life insurance policy.

**Limitation of Authority**

**No Agent or medical examiner has any right to accept any risk, make or change contracts, give up any of our rights or requirements, or change the provisions of this Agreement.**



**NEW YORK LIFE INSURANCE AND ANNUITY CORPORATION**

Received from \_\_\_\_\_ on \_\_\_\_/\_\_\_\_/\_\_\_\_ the  
sum of \_\_\_\_\_ Dollars (\$ \_\_\_\_\_). This amount  
is the sum of the Premium Paid amounts specified in Question 3 of the Application bearing the same date and number as this receipt.

Any check tendered should be payable to NYLIAC rather than to the Agent. The payee should not be left blank. Any check received will be subject to collection. This receipt is not transferable.

Receipt No. **XXXXXXXX**

**X** \_\_\_\_\_

Agent Signature (Agent must sign)

**THIS PAGE DOES NOT PRINT**

SERFF Tracking Number: NYLC-126159557 State: Arkansas  
Filing Company: New York Life Insurance and Annuity Corporation State Tracking Number: 42453  
Company Tracking Number: 209-538, ET AL.  
TOI: L08 Life - Other Sub-TOI: L08.000 Life - Other  
Product Name: Life & Annuity Single Premium Application  
Project Name/Number: Life & Annuity Single Premium Application/209-538, et al.

## Supporting Document Schedules

	Item Status:	Status Date:
<b>Satisfied - Item:</b> Flesch Certification <b>Comments:</b> <b>Attachment:</b> State Filing Readability.pdf		

	Item Status:	Status Date:
<b>Bypassed - Item:</b> Application <b>Bypass Reason:</b> N/A <b>Comments:</b>		

	Item Status:	Status Date:
<b>Satisfied - Item:</b> Replacement Certification <b>Comments:</b> <b>Attachment:</b> Replacement Cert - States.pdf		

	Item Status:	Status Date:
<b>Satisfied - Item:</b> Suitability Certification <b>Comments:</b> <b>Attachment:</b> Suitability Certification-non-compact states.pdf		

**NEW YORK LIFE INSURANCE AND ANNUITY CORPORATION**

**READABILITY CERTIFICATION**

**I certify that the forms listed on the attached page meet the standards of your State's Readability Requirements.**

**NEW YORK LIFE INSURANCE AND ANNUITY CORPORATION**

*Linda E. LoPinto*

---

**Signature**

---

**Linda E. LoPinto**

**Name**

---

**Corporate Vice President**

**Title**

---

**May 1, 2009**

**Date**

## NEW YORK LIFE INSURANCE AND ANNUITY CORPORATION

**Flesch Scores for forms submitted with this filing are:**

<b><u>Form No.</u></b>	<b><u>Flesch Score</u></b>
309-548	50
209-538	50
21620.200	51
21620.300	51

**NEW YORK LIFE INSURANCE AND ANNUITY CORPORATION**

**REPLACEMENT QUESTIONS CERTIFICATION**

**I certify that replacement questions will be included in a separate form when the individual life application form 309-548 and 209-538 is used.**

**NEW YORK LIFE INSURANCE AND ANNUITY CORPORATION**

*Linda E. LoPinto*

---

**Signature**

---

**Linda E. LoPinto**

**Name**

---

**Corporate Vice President**

**Title**

---

**May1, 2009**

**Date**

**NEW YORK LIFE INSURANCE AND ANNUITY CORPORATION**

**VARIABLE LIFE SUITABILITY AND DISCLOSURE CERTIFICATION**

**I certify that if variable life products are selected on individual life and annuity application form, 209-538 suitability questions and required disclosures will be included in a separate form.**

**NEW YORK LIFE INSURANCE AND ANNUITY CORPORATION**



---

**Signature**

---

**Linda E. LoPinto**

**Name**

---

**Corporate Vice President**

**Title**

---

**May 1, 2009**

**Date**

<i>SERFF Tracking Number:</i>	<i>NYLC-126159557</i>	<i>State:</i>	<i>Arkansas</i>
<i>Filing Company:</i>	<i>New York Life Insurance and Annuity Corporation</i>	<i>State Tracking Number:</i>	<i>42453</i>
<i>Company Tracking Number:</i>	<i>209-538, ET AL.</i>		
<i>TOI:</i>	<i>L08 Life - Other</i>	<i>Sub-TOI:</i>	<i>L08.000 Life - Other</i>
<i>Product Name:</i>	<i>Life &amp; Annuity Single Premium Application</i>		
<i>Project Name/Number:</i>	<i>Life &amp; Annuity Single Premium Application/209-538, et al.</i>		

## Superseded Schedule Items

Please note that all items on the following pages are items, which have been replaced by a newer version. The newest version is located with the appropriate schedule on previous pages. These items are in date order with most recent first.

Creation Date:	Schedule	Schedule Item Name	Replacement Creation Date	Attached Document(s)
05/20/2009	Form	Application for Single Premium Universal Life Insurance and/or Single Premium Deferred Fixed Annuity	11/03/2009	309-548AR.pdf (Superceded)



**NEW YORK LIFE** Application for Single Premium Universal Life Insurance and/or Single Premium Deferred Fixed Annuity  
New York Life Insurance and Annuity Corporation (NYLIAC) (A Delaware Corporation)

Executive Office: 51 Madison Avenue, New York, NY 10010 • Home Office: 200 Continental Drive, Suite 306, Newark, DE 19713

**1. PROPOSED INSURED/ANNUITANT INFORMATION**

First Name	Middle Name	Last Name	Suffix	<input type="checkbox"/> Male <input type="checkbox"/> Female	Date of Birth (mm/dd/yyyy)
Residence: Street	City	State	Country	Zip	Home Telephone (Evening) Business Telephone (Day)
<input type="checkbox"/> Social Security No. or <input type="checkbox"/> Tax I.D. No. <input type="checkbox"/> Exempt <input type="checkbox"/> Applied for					
Country of Citizenship	Country of Birth	State of Birth	How Long Living in the USA? <input type="checkbox"/> Since Birth or _____ Years _____ Months		
Immigration Visa or Work Authorization: (If other than a US citizen)	Expiration	Occupation			
Type	Number	Month	Year		
Employer Name:	Street	City	State	Country	Zip

*If the Owner, Joint Owner, Applicant, or Payer is not the Proposed Insured/Annuitant, please provide the appropriate additional information in Section 5.*

**2. MEDICAL AND PERSONAL INFORMATION (Applies only to Single Premium Universal Life Insurance)**

- A. Has the Proposed Insured used tobacco, nicotine, or any nicotine substitution product in any form in the last twelve (12) years? . . . . . ☐ Yes ☐ No
- B. In the last 90 days, has the Proposed Insured been recommended by a physician or other medical practitioner to undergo diagnostic procedures or tests for any symptoms, illnesses or other conditions? (If "Yes," please provide additional information in Section 7) . . . . . ☐ Yes ☐ No
- C. In the last two (2) years, has the Proposed Insured been admitted to a hospital or other medical facility for a medical illness or major surgical procedure? . . . . . ☐ Yes ☐ No
- D. In the last five (5) years, has the Proposed Insured been diagnosed by a member of the medical profession or tested positive for Human Immunodeficiency Virus (AIDS virus) or Acquired Immune Deficiency Syndrome (AIDS)? . . . . . ☐ Yes ☐ No
- E. In the last five (5) years, has the Proposed Insured been diagnosed, treated, tested positive for or been given medical advice by a member of the medical profession for any of the conditions below? (If "Yes," circle all applicable conditions)

1) Heart attack, chest pains, or heart disorder, angina, heart surgery, or angioplasty	<input type="checkbox"/> Yes <input type="checkbox"/> No	7) Pancreatitis, hepatitis, cirrhosis, kidney failure, or a condition requiring dialysis	<input type="checkbox"/> Yes <input type="checkbox"/> No
2) Stroke or transient ischemic attack (TIA)	<input type="checkbox"/> Yes <input type="checkbox"/> No	8) Anemia requiring blood transfusions	<input type="checkbox"/> Yes <input type="checkbox"/> No
3) Vascular disease (peripheral vascular disease, aneurysm, artery blockage)	<input type="checkbox"/> Yes <input type="checkbox"/> No	9) Any major psychiatric or mental condition requiring hospitalization	<input type="checkbox"/> Yes <input type="checkbox"/> No
4) Diabetes requiring insulin treatment	<input type="checkbox"/> Yes <input type="checkbox"/> No	10) Drug or alcohol abuse	<input type="checkbox"/> Yes <input type="checkbox"/> No
5) Any form of malignant cancer or tumor, leukemia, Hodgkin's disease, or lymphoma requiring chemo/radiation therapy	<input type="checkbox"/> Yes <input type="checkbox"/> No	11) Unexplained weight loss exceeding twenty (20) pounds	<input type="checkbox"/> Yes <input type="checkbox"/> No
6) Chronic bronchitis, emphysema (COPD), or any condition requiring oxygen therapy	<input type="checkbox"/> Yes <input type="checkbox"/> No	12) Muscular dystrophy, ALS, lupus, multiple sclerosis, seizures, Alzheimer's disease or other neurological disorder	<input type="checkbox"/> Yes <input type="checkbox"/> No

**3. PRODUCT SELECTION AND PREMIUM – If "No" is answered in Section 2 for Questions C and D, and all conditions listed in Question E, one or both products may be selected. If "Yes" is answered in Section 2 for Questions C or D, or any condition listed in Question E, only a Single Premium Deferred Fixed Annuity may be selected. If applicable, make check payable to NYLIAC.**

- ☐ **Single Premium Universal Life Insurance** (If 'Yes' is answered to Question B in Section 2 above, do not collect life insurance premium. Temporary Coverage is not available.)

Face Amount: \$ \_\_\_\_\_ Premium: \$ \_\_\_\_\_ Premium Paid: \$ \_\_\_\_\_ (Optional. If paid, must be equal to full premium.)

- ☐ **Single Premium Deferred Fixed Annuity** (Annuity commencement at the later of age 90 or 10 years for all products. Do not use for Qualified Plans)  
(Choose ONE annuity product below. All products may not be available in all jurisdictions.)

- ☐ New York Life Enhanced Fixed Annuity (EFA)\*

Surrender Charge Period (check one box for EFA only)

☐ 6 Years ☐ 8 Years

- ☐ New York Life Preferred Fixed Annuity (PFA)

- ☐ New York Life Optimal Fixed Annuity (OFA)

- ☐ New York Life Select 5 Fixed Annuity (S5FA)

- ☐ Other: \_\_\_\_\_

\*During the initial Interest Rate Guarantee Period, a higher interest rate will be credited to policies issued with an 8-Year Surrender Charge period.

Client Profile and Policy Disclosure Form **required** with all Single Premium Deferred Fixed Annuity applications.



### 3. PRODUCT SELECTION AND PREMIUM (Continued)

#### Single Premium (EFA, PFA, OFA, & S5FA)

\$ \_\_\_\_\_ (indicate total estimated amount including cash with application and anticipated transfer/exchange amounts)

Premium Paid \$ \_\_\_\_\_

**Initial Interest Rate Guarantee Period** (5 Years only for Select 5. All others check one box below.)

☐ 1 Year (EFA, PFA, OFA)    ☐ 3 Years (EFA, PFA, OFA)    ☐ 6 Years (EFA)    ☐ 7 Years (PFA)

☐ Other: \_\_\_\_\_

### 4. BENEFICIARY(IES)

- If more than one Beneficiary is named, indicate the class and percentage for each. Each class for each product must total 100%.
- If applicable, use Section 7, "Additional Details," to provide additional Beneficiary information.

#### Single Premium Universal Life Insurance Beneficiaries

(if applicable)

☐ **Trust** (Provide details in Section 7)

☐ **UTMA/UGMA** (Provide details in Section 7)

##### Class

**Primary** \_\_\_\_\_  %  
Name (First, Middle, Last, Suffix) Percentage

☐ **Primary** \_\_\_\_\_  
Relationship to Proposed Insured

☐ **Contingent** \_\_\_\_\_  %  
Name (First, Middle, Last, Suffix) Percentage

\_\_\_\_\_  
Relationship to Proposed Insured

#### Single Premium Deferred Fixed Annuity Beneficiaries (if applicable)

☐ **Same Beneficiary designations for both products**

☐ **Surviving Spouse Under Joint Spousal Ownership**

☐ **Trust** (Provide details in Section 7)

☐ **UTMA/UGMA** (Provide details in Section 7)

##### Class

**Primary** \_\_\_\_\_  %  
Name (First, Middle, Last, Suffix) Percentage

☐ **Primary** \_\_\_\_\_  
Relationship to Proposed Annuitant

☐ **Contingent** \_\_\_\_\_  %  
Name (First, Middle, Last, Suffix) Percentage

\_\_\_\_\_  
Relationship to Proposed Annuitant

### 5. OTHER PARTY INFORMATION

#### A. Owner Information (if not the Proposed Insured/Annuitant)

☐ Individual ☐ Trust ☐ Corp. If Individual, provide:

Owner (First, Middle, Last, Suffix) Birth Date (mm/dd/yyyy) ☐ Male ☐ SSN or ☐ Tax I.D. No. ☐ Exempt ☐ Applied for  
☐ Female

Residence (Street, City, State, Country, Zip Code) Home Telephone (Evening) Business Telephone (Day)

Country of Citizenship Country of Birth State of Birth Relationship to Proposed Insured/Annuitant

If not a US citizen, type of immigration visa or work authorization: \_\_\_\_\_ Number: \_\_\_\_\_ Expiration (mm/yyyy): \_\_\_\_\_

If Trust: Name of Trust Date of Trust State Where Trust Established

Name of Trustee(s) Relationship of Trustee(s) to Proposed Insured/Annuitant

Trust Beneficiary(ies) Relationship of Trust Beneficiary(ies) to Proposed Insured/Annuitant

Is the trust a grantor trust? ☐ Yes ☐ No If "Yes" and the grantor is an individual: \_\_\_\_\_  
Grantor's Name (First, Middle, Last, Suffix)

If joint ownership: The joint owner ☐ **is** ☐ **is not** the Proposed Insured/Annuitant. (If not the Proposed Insured/Annuitant, provide information for joint owner in Section 7, "Additional Details." Unless otherwise specified in Section 7, ownership will be joint with right of survivorship.)

#### B. Applicant Information (if not the Proposed Insured/Annuitant or Owner)

Name (First, Middle, Last, Suffix) Birth Date (mm/dd/yyyy) ☐ Male ☐ SSN or ☐ Tax I.D. No. ☐ Exempt ☐ Applied for  
☐ Female

Residence (Street, City, State, Country, Zip Code) Relationship to Proposed Insured/Annuitant



## 5. OTHER PARTY INFORMATION (Continued)

### C. Payer Information (if not the Proposed Insured/Annuitant)

Same as ☐ Owner ☐ Applicant

Name (First, Middle, Last, Suffix)	Birth Date (mm/dd/yyyy)	<input type="checkbox"/> Male <input type="checkbox"/> Female	<input type="checkbox"/> SSN or <input type="checkbox"/> Tax I.D. No. <input type="checkbox"/> Exempt <input type="checkbox"/> Applied for
Residence (Street, City, State, Country, Zip Code)			Relationship to Proposed Insured/Annuitant
Relationship to Owner (if other than Proposed Insured/Annuitant)			

### D. Secondary Addressee - Owner may designate a secondary addressee to receive notice of potential lapse of coverage.

Name (First, Middle, Last, Suffix)	Residence (Street, City, State Country, Zip Code)
------------------------------------	---------------------------------------------------

## 6. SALES INTERVIEW

In which language and dialect(s) was the sales interview conducted? Language: \_\_\_\_\_ Dialect(s): \_\_\_\_\_

If a language other than English, who acted as interpreter? ☐ Agent ☐ Other: \_\_\_\_\_  
Name (First, Middle, Last, Suffix) Relationship to Proposed Insured/Annuitant

## 7. ADDITIONAL DETAILS - Check the appropriate box(es) below and provide specific details in the lines below.

☐ No Driver's License ☐ Diagnostic Procedure or Test Within 90 Days ☐ Additional Beneficiary Information ☐ Trust is a Beneficiary  
☐ UTMA/UGMA ☐ Joint Owner Information ☐ Successor Owner ☐ Reinstatement ☐ Special Processing Instructions ☐ Other

## ILLUSTRATION (Applies only to Single Premium Universal Life Insurance)

**Do not complete this section if a signed illustration is not required by law or an illustration was signed and matches the policy applied for.**

I, the Applicant, did not sign an illustration because:

- ☐ An illustration was not shown or given to me
- ☐ An illustration was shown or given to me, but the policy applied for is different from the illustration
- ☐ An illustration was shown to me on a screen. The displayed illustration matches the policy applied for, but no printed copy of the illustration was furnished.  
The illustration on the screen included the following personal and policy information:

Proposed Insured: \_\_\_\_\_ Age: \_\_\_\_\_ Gender: ☐ Male ☐ Female

Type of Policy: \_\_\_\_\_ Initial Death Benefit: \$ \_\_\_\_\_ Rating/Class: \_\_\_\_\_

I acknowledge that I did not sign an illustration for the reason stated above and I understand that an illustration matching the policy as issued will be provided for signature no later than at the time the policy is delivered.

## FRAUD WARNING

**Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.**

## STATEMENT OF AGREEMENT

### Those Persons Who Sign This Application Agree That:

1. All of the statements and answers to questions which are part of the application are correctly recorded, and are complete and true to the best of the knowledge and belief of those persons who made them. Answers that are not true and complete may, subject to the policy's contestability provision, invalidate coverage.
2. No agent or medical examiner has any right to accept risks, make or change contracts, or give up NYLIAC's rights or requirements.
3. For life insurance,
  - a. "Cash Paid" with the application with respect to a new policy or additional benefit, provides a limited amount of temporary coverage for up to 90 days, if the terms and conditions of the Temporary Coverage Agreement are met.
  - b. The policy date is the date from which premiums are calculated and become due. The effective date is the date the policy is delivered and the first premium is paid. Unless temporary coverage is obtained, coverage does not begin until the effective date. If the policy date is earlier than the effective date of coverage, the policyowner pays a premium calculated beginning on that earlier policy date although coverage does not begin until the effective date. If no temporary coverage is obtained, the date that the policy is issued will be the policy date. It is further agreed and understood that interest will not be credited on the policy until the premium is received by the service office.
  - c. The Applicant has received and read a copy of the Accelerated Benefits For Terminal Illness Disclosure. Receipt of accelerated death benefits may affect eligibility for public assistance programs and may be taxable; as with all tax matters, a personal tax advisor should be consulted.
4. For annuities, the policy will not become effective unless it is delivered to the Owner while the Owner and Annuitant are living.



## TAX CERTIFICATION

Under penalties of perjury, I (as the Owner named in Section 1 or 5) certify that: (1) the Social Security or Employer ID Number shown in this application is my correct taxpayer identification number, or I am awaiting a number to be issued to me (noted as "applied for" in Section 1 or 5) AND (2) I am not subject to backup withholding because: (a) I am exempt from backup withholding; or (b) I have not been notified by the IRS that I am subject to backup withholding as a result of a failure to report all interest or dividends; or (c) the IRS has notified me that I am no longer subject to backup withholding (Cross out item 2 if the IRS has notified you that you are subject to backup withholding) and (3) I am a U.S. person (including a U.S. resident Alien).

### ACKNOWLEDGEMENT AND AUTHORIZATION (*Applies only to Single Premium Universal Life Insurance*)

#### ACKNOWLEDGEMENT

I, the Proposed Insured, have been given a copy of "Information Practices Related to Underwriting Your Application" which tells how NYLIAC obtains and uses data about me. It includes the notice required by the State and Federal Fair Credit Reporting Acts and a description of MIB, Inc. (Medical Information Bureau). I know that my application cannot be processed if I do not sign the authorization below.

#### AUTHORIZATION

In this Authorization, "I" means the Proposed Insured, "the Insurer" means NYLIAC and its respective agents, employees, and representatives. In order to see if (and on what basis) I qualify for the insurance applied for or any other insurance offered by the insurers identified above, I authorize the following:

**MEDICAL INFORMATION:** Physicians or practitioners; hospitals; medical or medically related facilities; pharmacies, pharmacy benefit managers or medical information retrieval services; laboratories; insurance companies; or MIB may give to the Insurer (or any consumer reporting agency acting on its behalf) and to any of its reinsurers, at my request, copies of the record or other data that they may have about my physical and mental health, and my prescription drug history. This includes all protected health information and any health information I have previously requested be withheld from further disclosure, and including my history, their findings, diagnoses and treatment. Mental health professionals may provide their records of my diagnosis, functional status, treatment plan, symptoms, prognosis, progress to date, medication prescription and monitoring, and clinical test results.

**OTHER UNDERWRITING INFORMATION:** MIB and other insurance companies may give to the Insurer and to any of its reinsurers data about: my driving record; any criminal activity or association; hazardous sport or aviation activity; use of alcohol or drugs; any claim of eligibility for disability income benefits; and other applications for insurance.

**EXAMINATIONS AND TESTS:** The Insurer may obtain physical examinations or medical tests deemed necessary to underwrite my application. These tests (where permitted by law) may include but are not limited to, electrocardiograms, chest x-rays and tests of blood and urine to determine, among other things, exposure to causative agents of disease (for example, exposure to AIDS virus) and the presence of drugs. However, a separate notification/authorization form will be provided with respect to testing for the AIDS virus.

**INVESTIGATIVE CONSUMER REPORT:** The Insurer may obtain an investigative consumer report and may give the consumer reporting agency information concerning the amount and type of my coverage and my use, if any, of tobacco. The report may add to or confirm the types of data mentioned above. It may also contain data about: my identity; age; residence; marital status; past and present jobs (including work duties); economic conditions; driving record; personal and business reputation in the community; and mode of living; but will not include any information relating directly or indirectly to sexual orientation.

**IDENTIFICATION:** To obtain the data described above, the Insurer may give my name, address, and date and place of birth to the above persons or organization.

**RELEASE OF INFORMATION TO OTHERS:** When necessary, the Insurer may give data about me that affects my insurability to: its subsidiaries; its affiliates; its parent company; its agents and their staffs; its reinsurers; and the Insurer and its reinsurers may give such data to MIB. However, this will not be done in connection with information relating to the AIDS virus.

This Authorization may be used for a period of 24 months from the date signed below unless sooner revoked. I may revoke this Authorization at anytime by notifying the Insurer in writing. This revocation will not be effective to the extent the Insurer or any other person already has disclosed or collected information or taken other action in reliance on it. The information the Insurer obtains through this Authorization may become subject to further disclosure. For example, the Insurer may be required to provide it to an insurance regulatory or other government agency. In this case, the information may no longer be protected by the rules governing this Authorization. A photocopy of this Authorization and request form shall be as valid as the original. I know that I may request a copy of this Authorization. (Please provide a copy to me. \_\_\_\_\_ initial if requested).

### The Internal Revenue Service Does Not Require Your Consent To Any Provision Of This Document Other Than The Certifications Required To Avoid Backup Withholding.

#### SIGNATURES

By signing below, I/We understand that I/We acknowledge and agree to all of the statements, representations, and disclosures made in this application, including sections entitled Statement of Agreement, Illustration (*if applicable*), Tax Certification, and Acknowledgment and Authorization (*if applicable*). I/We accept and adopt as true all statements made by the Proposed Insured/Annuitant in this application.

**X** \_\_\_\_\_ Signed at \_\_\_\_\_ On \_\_\_\_\_  
Signature of the Proposed Insured/Annuitant (City, State) (mm/dd/yyyy)

**X** \_\_\_\_\_  
Signature of Owner if Other than the Proposed Insured/Annuitant Title if signed on behalf of Corporation, Trust, etc.

**X** \_\_\_\_\_  
Signature of Applicant if Other than Proposed Insured/Annuitant or Owner

I Certify I have truly and accurately recorded all answers given to me.

**X** \_\_\_\_\_ **X** \_\_\_\_\_  
Signature of Agent/Witness Countersigned by Licensed Resident (*if required*)

**X** \_\_\_\_\_  
Signature of Agent/Witness Countersigned Code Number